MaineCare Services
An Office of the
Department of Health and Human Services

Department of Health and Human Services
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Paul R. LePage, Governor *Mary C. Mayhew, Commissioner*

DATE: March 30, 2012

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Adoption emergency rule – Chapter 101. MaineCare Benefits Manual, Section 15, Chapter II, ***Chiropractic Services***

The Department is adopting changes to Chapter 101, MaineCare Benefits Manual, Section 15, Chapter II, Chiropractic Services, pursuant to Public Law 2011, Chapter 477, the Maine State Supplemental Budget enacted by the 125th Maine State Legislature and signed into law by Governor Paul R. LePage on February 23, 2012. This emergency rule is being adopted in accordance with Part M, requiring that, effective April 1, 2012, MaineCare Services reimburse Section 15, Chiropractic Services, only up to a strict limit of twelve (12) visits per rolling calendar year for adult members. The adoption of this emergency rule is estimated to save $29,072 for State Fiscal Year (SFY) 2012 and $157,805 for SFY 2013, respectively.

Rules and related rulemaking documents may be reviewed at and printed from the MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/index.shtml or, for a fee, interested parties may request a paper copy of rules by calling (207) 287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-606-0215.

If you have any questions regarding the policy, please contact Provider Services at 1-866-690-5585 or TTY: 711.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Section 15, Chapter II, ***Chiropractic Services***

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The Department is adopting changes to Chapter 101, MaineCare Benefits Manual, Section 15, Chapter II, Chiropractic Services pursuant to Public Law 2011, Chapter 477, the Maine State Supplemental Budget enacted by the 125th Maine State Legislature and signed into law by Governor Paul R. LePage on February 23, 2012. This emergency rule is being adopted in accordance with Part M, requiring that effective April 1, 2012, MaineCare Services reimburse Section 15, Chiropractic Services only up to a strict limit of twelve (12) visits per rolling calendar year for adult members. The adoption of this emergency rule is estimated to save $29,072 for State Fiscal Year (SFY) 2012 and $157,805 for SFY 2013, respectively.

See http://www.maine.gov/dhhs/oms/rules/index.shtml **for rules and related rulemaking documents.**

EFFECTIVE DATE: April 1, 2012

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SECTION 15 **CHIROPRACTIC SERVICES** Established: 9/15/80
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15.01 PURPOSE

The Department's purpose for this rule is to provide medically necessary chiropractic services to MaineCare members who are adults (age twenty-one (21) and over) with rehabilitation potential, and medically necessary chiropractic services to MaineCare members who are under age twenty-one (21).

15.02 DEFINITIONS

15.02-1 **Chiropractic Services** are those services provided to a member by a licensed chiropractor.

15.02-2 **Chiropractor** is an individual who both is licensed by the state or province in which he/she provides chiropractic services and meets uniform minimum standards promulgated by the Secretary of Health and Human Services under 42 U.S.C. §1395 X (r) and 42 CFR 440.60.

15.02-3 **Rehabilitation Potential** is a documented expectation by the member's physician or PCP that the member's condition will improve significantly in a reasonable, predictable period of time as a result of the prescribed treatment plan. The physician's documentation of rehabilitation potential must include the reasons used to support this expectation. New rehabilitation potential documentation must be reauthorized per episode of unrelated conditions.

15.03 ELIGIBILITY FOR CARE

Individuals must meet the financial, residency and eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify a member's eligibility for MaineCare, as described in Chapter I of the MaineCare Benefits Manual (MBM), prior to providing services.

15.04 SPECIFIC ELIGIBILITY FOR CARE

Covered services for members of all ages must be medically necessary. The Department or its authorized agent has the right to perform eligibility determination and/or utilization review to determine if services provided were medically necessary.

Adult members (age twenty-one (21) and over) must have an initial evaluation by a physician that documents the member's rehabilitation potential. This requirement will not apply to members with Medicare coverage or other third party health insurance while meeting a deductible. This requirement will also not apply to members with Medicare coverage or other third party health insurance until the coverage for chiropractic services by the other payor has been exhausted.

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15.05 **COVERED SERVICES**

The Department can make payment for covered services that are specifically included in the Department's MBM, Chapter III, Section 15, Allowances for Chiropractic Services. Covered services are limited to the following:

A. Manual or mechanical manipulation of the spine. The diagnosis must indicate a subluxation. Separate reimbursement for an examination/diagnosis will not be made.

B. X-ray services that are medically necessary for diagnosis and treatment of a subluxation.

15.06 **NON-COVERED SERVICES**

MaineCare reimbursement shall cover only x-rays of the spine and will not cover x-rays that are not of the spine. Any service not described and/or listed in Chapters II and III, Section 15, is considered a non-covered service.

15.07 **LIMITATIONS**

Emergency Effective 04/01/12

A. Reimbursement for acute and chronic care episodes for MaineCare members ages twenty-one (21) and over shall be strictly limited to twelve (12) visits per rolling calendar year and based upon medical necessity. Medical necessity must be supported and documented in accordance with criteria defined in Section 15.08-3, Member Records. The Department reserves the right to request additional information to evaluate medical necessity.

B. Reimbursement and limitations on the number of x-rays will be based upon the criteria of medical necessity and documentation as specified in Section 15.08-3, Member Records.

C. When repeat x-ray examinations of the same body part and for the same condition are required because of technical or professional error in the original x-rays, such repeat x-rays are not a covered service and are not reimbursable by MaineCare.

15.08 **POLICIES AND PROCEDURES**

15.08-1 **Diagnosis**

A. The diagnosis of subluxation must be demonstrated by a recent x-ray or a recent examination documenting a clinical manifestation of a subluxation.

B. A recent examination must include but is not limited to the examinations listed below:

15.08 **POLICIES AND PROCEDURES** (cont.)

1. Mensuration;

2. Biomechanical Evaluation;

3. Neurological Evaluation;

4. Kinesiological Evaluation; and

5. Orthopedic Evaluation.

C. Examination by observation and palpation (static and/or dynamic) will be accepted as fulfilling the requirements of Section 15.08-1(A) above if all other examinations listed in Section 15.08-1(B) above have been performed and abnormal findings are absent.

D. Recent examination and/or x-ray are interpreted to mean an examination or x-ray was made within thirty (30) days prior to the initiation of treatment.

If for any reason a course of treatment is discontinued for a period longer than one (1) year, re-examination is required for treatment to be a covered service.

E. MaineCare members who also qualify for Medicare shall meet the diagnostic requirements of the Medicare program.

15.08-2 **Treatment Exceeding Six (6) Months**

Ongoing treatments require justification in the form of a recent examination or x-ray documenting a clinical manifestation of subluxation six (6) months after treatment first begins and every twelve (12) months thereafter. Recent examinations or x-rays used to justify treatment that exceeds six (6) months in duration, must fulfill the requirements of Section 15.08-1. The results of these examinations or x-rays should be made a part of the member record.

15.08-3 **Member Records**

The Department requires a specific record for each member that includes but is not limited to:

A. The member’s name, address, birthdate, and MaineCare I.D. number.

B. The member’s social and medical history, and diagnoses.

C. A personalized plan of service including (at a minimum):

15.08 **POLICIES AND PROCEDURES** (cont.)

1. Type of chiropractic services needed;

2. How the services can best be delivered, and the provider who will deliver the services;

3. Frequency of services and expected duration of services;

4. Long and short range goals;

5. Plans for coordination with other health service providers for the delivery of services and the transfer of x-rays, if needed; and

6. Documentation of x-ray findings or results of the examinations described in 15.08 supporting the medical necessity of the services to be delivered.

See Chapter I of the MBM for additional documentation requirements.

D. The physician or primary care provider's documentation of an adult member's rehabilitation potential.

E. Written progress notes that must be maintained and includes:

1. The name of the provider, a full description of the condition, and the date of each service provided;

2. Any progress toward the achievement of established long and short-range goals;

3. The signature of the servicing provider for each service; and

4. A full account of any unusual condition or unexpected event, including the date when it was observed.

The Department requires entries to be made for each service billed. When the services delivered vary from the plan of care, entries in the member's record must justify the changes.

15.08-4 **The Division of Program Integrity**

Please see the MBM, Chapter I, General Administrative Policies and Procedures for information on the Division of Program Integrity.

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15.09 **REIMBURSEMENT**

A. The payment amount for services rendered shall be the lowest of the following:

1. The amount listed in the "Allowances for Chiropractic Services," Chapter III, MBM; or

2. The lowest amount allowed by the Medicare Part B carrier; or

3. The provider's usual and customary charge; or

4. The amount, if any, by which the MaineCare rate of reimbursement for services billed exceeds the amount of the third party payment as set in Chapter I of the MBM. MaineCare considers a claim paid in full if the insurance amount received exceeds the MaineCare rate of reimbursement.

B. In accordance with Chapter I of the MBM, it is the responsibility of the provider to ascertain from each member whether there are any other resources (private or group insurance benefits, worker's compensation, or other liable third parties) that are available for payment of the rendered service, and to bill that potential payor prior to billing MaineCare.

C. Please refer to Chapter I of the MBM for reimbursement criteria for interpreter services.

15.10 **COPAYMENT**

15.10-1 **Copayment Amount**

A. A copayment will be charged to each MaineCare member receiving services. The amount of the copayment shall not exceed $2.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 or more	$2.00

B. The member shall be responsible for copayments up to $20.00 per month whether the copayment has been paid or not. After the $20.00 cap has been reached, the member will not be required to make additional copayments and the provider will receive full MaineCare reimbursement for covered services.

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15.10 **COPAYMENT** (cont.)

C. No provider may deny services to a member for failure to pay a copayment. Providers must rely upon the member's representation that he or she does not have the resources available to pay the copayment. A member's inability to pay a copayment does not, however, relieve him/her of liability for the copayment.

D. Providers are responsible for documenting the amount of copayments charged to each member regardless of whether the member has made payment.

15.10-2 **Copayment Exemptions and Dispute Resolution**

Refer to the MBM, Chapter I, General Administrative Policies and Procedures for copayment exemption and dispute resolution policies.

15.11 **BILLING INSTRUCTIONS**

A. Providers must bill in accordance with the Department's current Billing Instructions.

B. All services provided on the same day shall be submitted on the same claim form for MaineCare reimbursement.